patients with UB records categorized by inpatient DRGs is multiplied by each hospital's equalization factor for the appropriate DRGs and hospitals. The median equalized cost of all such records in all hospitals calculated after teaching costs have been removed from the hospitals' Preliminary Costs Bases is the incentive standard for each DRG.

2. Determination of Labor Unequalization Factor to Calculate Standard Cost Per Case of Each Labor Market Area.

i An unequalization factor shall be calculated for the non-physician direct patient care costs of each hospital to account for differing prevailing compensation patterns across New Jersey's Labor Market Areas in the comparison of hospital and standard costs per case. The Statewide standard times the unequalization factor is the unequalized standard in terms of the hospital's Labor Market Area.

ii The reciprocal of the hospital's equalization factor is the hospital's unequalization factor and is applied to non-physician costs only.

(d) GME and IME shall no longer be reimbursed through the Medicaid hospital inpatient DRG rates. After all indirect costs have been fully allocated to the using cost centers, GME and IME cost shall be removed from the cost base before calculating the standards and Medicaid hospital inpatient rates. GME and IME shall be reimbursed in accordance with sections 8.1 through 8.4.

5.15 Reasonable Direct Cost Per Case

(a) Inpatient direct cost per case shall be determined as follows:

1. The Reasonable Direct Cost Per Medicaid Case for those hospitals receiving rates in accordance with this subsection determined for all hospitals, for every DRG, shall include a standard and the following factors:

   i. A factor to equalize the standard to the hospital's labor market region through the unequalization factor.

   ii. A factor to adjust for the hospital's physician cost through the physician markup factor applied to the standard.

(b) Inpatient Outlier: (refer to Section 7.2 and Appendix 1.4 and 1.6)

1. Low Length of Stay (LLOS) Outlier: The total standard cost of LLOS outlier cases for each DRG, shall be divided by the LLOS days to arrive at a LLOS Unadjusted Per Diem. For payment, the LLOS Unadjusted Per Diem is adjusted by hospital by the factors referenced in Section 5.15(a)1.i. through v.

2. High Length of Stay Outlier (HLOS): The inlier standard cost for each DRG shall be multiplied by that DRG's total number of cases with acute days of service greater than the high trim point (HLOS cases). This amount is subtracted from the DRG's total standard cost of all HLOS cases. This value is then divided by the total number of HLOS days for that DRG to arrive at the HLOS Unadjusted Per Diem. For payment, each HLOS Unadjusted Per Diem is adjusted for the factors referenced in Section 5.15(a)1.i. through v.

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5.16 Net Income From Other Sources

(a) The net gain (loss) from Other Operating and Non-Operating Revenues (as defined in Sections 6.27 through 6.33) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see Sections 6.27 through 6.33) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non-Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in Sections 6.27 through 6.33.

5.17 Update Factors

(a) Economic Factor: The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. It is to be based, as far as possible, on recorded price changes. For that part of the period covered by an economic factor for which a recorded price change is unavailable, the economic factor shall be based on the best available forecast of price trends. The economic factor will be compounded from year-to-year based on the 1988 Base Year. A Global Economic Factor which was established by a panel selected by the Commissioner of Health was used for 1993.

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1. For 1988 through 1991, hospital-specific economic factors were computed. Each hospital's 1988 cost was multiplied by the actual proxy for each component. The result was used to compute a weighted average of the change in value for the components.

   i. The cost components of the economic factor and the weights given to each component are shown in Appendix 1.3. The weight given to each cost component is its proportion to total hospital expenditures.

2. A Global Economic Factor which was established by a panel selected by the Commissioner of Health was used for 1992. The 1993 portion of the Economic Factor was developed by the Department of Health using the Panel's methodology.

(b) Technology Factor: The technology factor takes into account the costs of adopting quality-enhancing technologies.

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1. Technology Factor: Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies.

2. The Technology Factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost-increasing technologies, and ProPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC.

   i. For 1992 and 1993, ProPac eliminated Technologies Not Included and Cost Decreasing Technologies. The Department of Health substituted an averaging method.

   ii. Beginning in 1994, rates will not be adjusted for a technology factor.

(c) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be $72,139 in 1988 dollars.

2. Heart Transplants: payment for DRG 103 will be $72,438 in 1988 dollars.

3. Cochlear Implants: payment for DRG 759 will be $21,608 in 1988 dollars.

4. Bone Marrow Transplants: payment for DRG 481 will be $46,599 in 1988 dollars.

5. Neonate rates, DRGs 600 through 630, will be based on 1989 actual New Jersey cost data.

(d) For determination of the payment rates, direct patient care is increased for the following components:

i.	Indirect patient care for items other than listed in Section 5.11;
ii.	Health planning fees;
iii.	Capital facilities allowance in Section 5.18;
iv.	Physician fee for service;
v.	Child Psychiatric hospital direct and indirect;
vi.	Special perinatal expense adjustment;
vii.	Trauma center adjustment;
xiii.	Hemophilia adjustment;
ix.	Regional perinatal adjustment;
x.	Pediatric rate adjustment;
xi.	Sickle cell adjustment;
xii.	Continuous adjustments;
xiii.	Outlier reversal adjustment; and
xiv.	Poison control cost.

Reference is made to pages I-170 through I-172.

(e) No Statewide transition adjustment not otherwise specified in this chapter will be included in this rate.

(f) Personnel Health allowance: This hospital-specific factor is applied to the entire rate. See 5.20(b) for explanation.

5.18 Capital Facilities

I. Capital Facilities, as defined in Section 6.18, shall be included in the rate in the following manner:

VII. The State agency will provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing homes, home health agencies, clinics, laboratories, and other appropriate institutions to assist them (a) to qualify for payment for authorized services rendered to persons eligible for medical assistance; (b) to establish and maintain appropriate fiscal records, and (c) to provide information needed to determine the amounts of payments properly due for services rendered.

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Attachment 4.16-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

COOPERATIVE ARRANGEMENTS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

1. The State agency has made cooperative arrangements with State health and State vocational rehabilitation agencies (including agencies which administer or supervise health or vocational rehabilitation services) directed toward maximum utilization of such services in the provision of medical assistance under the plan.

2. The State agency has made cooperative arrangements with grantees under Title V of the Social Security Act to provide for utilizing such grantee agencies in furnishing, to medical assistance recipients, care and services which are available under Title V plans or projects and are included in the State plan for Title XIX. Such arrangements include, where requested by the Title V grantee, provision for reimbursing the Title V grantee for care or services furnished by or through such grantee to individuals eligible therefor under the Title XIX plan, and are in writing.

3. The arrangements with State health and State vocational rehabilitation agencies, and with Title V grantees that request provision for reimbursement include a description, as appropriate, of the items specified in 45 CFR 251. 10 (a)(3).

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